Instructions for your New Patient Visit:

Appointment Date and Time: ___/___/____ at ____:____ AM / PM

PLEASE REQUEST WEILL CORNELL CONNECT CODE AT VISIT

Your Doctor:

- Claire Henchcliffe, MD, DPhil
- Harini Sarva, MD
- Alexander Shtilbans, MD, PhD
- Natalie Hellmers, MSN, RN, ACNP-BC

Approximate Visit Length: 60 minutes

- Attached Questionnaire
- Office notes and letter from your current Neurologist (If you have one.)

Please also bring to your appointment:

- Current Medication / Vitamin List (with strengths and dosages)
- Films/ CDS and Reports of relevant imaging (such as MRIs and CT Scans)
- Test Results (such as blood tests and EMG)
- Insurance Cards

★ Cancellation Policy: Our staff will call you in advance to confirm your scheduled appointment. If you are unavailable when we call, then we request that you call back as soon as possible to confirm. We reserve the right to cancel any appointments that have not been confirmed at least 2 business days in advance. We will also cancel if we have not received the attached questionnaire and letter from your primary care physician. These are mandatory for your visit. If advanced notification is not given regarding cancellations or changes to your appointment, you will be marked as a 'No Show'. If you accumulate 3 'No Shows' within 1 year, the physician has the right to dismiss you from the practice. Last, we ask that you are prompt to your appointment. Should you arrive late, you may run the risk of forfeiting your appointment. Thank you for your cooperation. ★
Name: _____________________________________________________  Appointment Date: ______________________

Address: ______________________________________________________________________________________________________

Date of Birth: _________________________________________

Age: __________

Phone Numbers:

Home: (______) ______________________________________________________________________________________

Work / Daytime: (______) _________________________________________________________________________________

Fax: (______) ____________________________________________________________________________________________

Mobile Phone: (______) _____________________________________________________________________________________

Health Care Proxy: ___________________________________ Relationship: ________________________________

Phone Number: (______) _____________________________________________________________________________________

E-mail Address: ___________________________________________________________________________________________

Do you have an official copy of your Health Care Proxy Form? Yes / No

If yes, Please provide us with a copy

Phone number: (______) _____________________________________________________________________________________

Emergency Contact Person:

Name: _____________________________________________________ Relationship: ________________________________

Phone Number: (______) _____________________________________________________________________________________

What is your preferred Pharmacy?

Name / Branch: _____________________________________________________________________________________________

Address: ________________________________________________________________________________________________

Phone Number: (______) _____________________________________________________________________________________

Who is your Primary Care Provider (Internist)?

Name: _________________________________________________________________________________________________

Address: ________________________________________________________________________________________________

Phone Number: (______) _____________________________________________________________________________________

Is this appointment a second consultation on a diagnosis?  Yes / No
Who referred you to our center?

Name: __________________________________________________________ Specialty: ____________________________
Address: ____________________________________________________________________________________________________________
Phone number: (______) ________________________________ Fax number: (______) ________________________________
Would you like us to send our consultation note to this person? Yes / No

What is the major neurological problem that brings you to the office today? Please make sure to have provided also your medical records for today’s visit.

______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________

Please circle any of the following that you have experienced as part of your illness:

- Slowness
- Changes with voice
- Clumsiness
- Difficulty walking
- Falling down
- Shoulder pain
- Memory Loss
- Weight Loss
- Depression
- Stiffness
- Other abnormal movements
- Changes in your handwriting
- Difficulty using your hands
- Balance Problems
- Poor posture/ hunching over
- Hallucinations
- Choking or Gagging
- Anxiety or panic attacks
- Acting out your dreams
- Tremor
Past Medical History
What medical problems do you have (or have you had in the past)? Please include hospitalizations.

_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________

List all surgeries or accidents that you have had, and the dates.

_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
_____________________________________________________________________________________________________________________________
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Smoking History:
Smoking Status circle one: Current, Never, Former
Quite date:
Types: Cigarettes, cigar, pipe
Packs per day
Years
Types: Snuff, Chew, smokeless tobacco
Quit Date: ______________________________
Alcohol: Yes / No
Intake per week:
_____ Wine
_____ Beer
_____ Liquor

Recreational drug usage? Y / N
If yes, which type: ____________________________________________________________

Occupation: _____________________________ Spouse name: _____________________________
Marital Status: __________________________ Spouse name: _____________________________
Number of children: ______
Years of education: ______
Family History:
Please fill in the table below for your parents
Name:
Mother: ___________________________________________________ Age: _____ Alive? Y / N
Father: ___________________________________________________ Age: _____ Alive? Y / N

Please list of any of your relatives have the following: (Father, mother, aunts, uncles, siblings, children, cousins, etc.)

Alzheimer's

Anxiety

Ataxia

Attention Deficit Disorder

Bipolar

Dementia

Depression

Dystonia

Essential Tremor

Huntington's Disease

Impulse Control Disorder

Movement Disorder

Parkinsonism

Parkinson's Disease

Substance abuse disorder

Other neurological disorder

Caffeine: Y / N ?
Do you use assistive devices? Y / N
Do you have a home health attendant? Y / N

Current height ______
Current weight ______
Allergies to medication or food? Please list reaction

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Are you allergic to contrast dye? Y / N

________________________________________________________________________________________________

Current Medications for Neurological conditions, Vitamins, and Supplements:
Please list the medication name, your dose, and when you take it.

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Any medications you may have taken for your neurological condition in the past that did not work:

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

Any other medications or supplements that you currently take:

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________

________________________________________________________________________________________________
In the past week, which symptoms have you experienced?

Please circle all that apply.

**Whole body symptoms**
- Weight loss or gain
- Fever
- Chills
- Night Sweats
- Poor Appetite
- Fatigue
- Insomnia
- Excessive daytime sleepiness

**Eye Problems**
- Vision Changes
- Double vision
- Eye pain or discharge
- Dry eyes

**Ear, nose, throat, or mouth problems**
- Hearing loss
- Ringing in the ears
- Ear pain
- Ear discharge
- Stuffy nose
- Runny nose
- Postnasal drip
- Nosebleeds
- Mouth Sores/Lesions
- Sore throat
- Swallowing problems

**Heart or blood vessel problems**
- Chest pain
- Palpitations
- Swelling
- Leg pain with walking
- Lightheadedness/near fainting
- Fainting
- Poor exercise tolerance

**Lung or breathing problems**
- Shortness of breath
- Coughing

**Gastrointestinal problems**
- Upset stomach or reflux
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Bloody or black stool
- Yellowing of the skin

**Musculoskeletal problems**
- Bone pain
- Muscle pains
- Joint pains
- Fractures

**Genital or urinary problems**
- Frequent urination
- Urgency to urinate
- Waking at night to urinate
- Painful or bloody urination
- Urinary incontinence
- Penile / vaginal discharge
- Genital lesions
- Erectile dysfunction
- Abnormal vaginal bleeding
- Abnormal menses

**Skin problems**
- Rashes
- Ulcers
- Abnormal hair loss
- Skin changes

**Endocrine problems**
- Heat intolerance
- Cold intolerance
- Urinating too often
- Abnormally thirsty
Other neurological symptoms
Weakness
Headache
Convulsions or Seizures
Vertigo
Tingling
Psychiatric Symptoms
Anxiety
Panic attacks
Depression
Hallucinations / illusions
Blood / lymphatic problems
Easy bleeding
Easy bruising
Swollen glands
Allergic / Immunology problems
Hives
Anaphylaxis
Skin tightness
Morning stiffness
Fingers changing color in the cold